167TH
ANNUAL REPORT
OF
THE SOCIETY OF
THE LYING-IN HOSPITAL
OF THE CITY OF NEW YORK

FOR THE YEAR

1965

530 EAST 70th STREET, NEW YORK, N. Y., 10021

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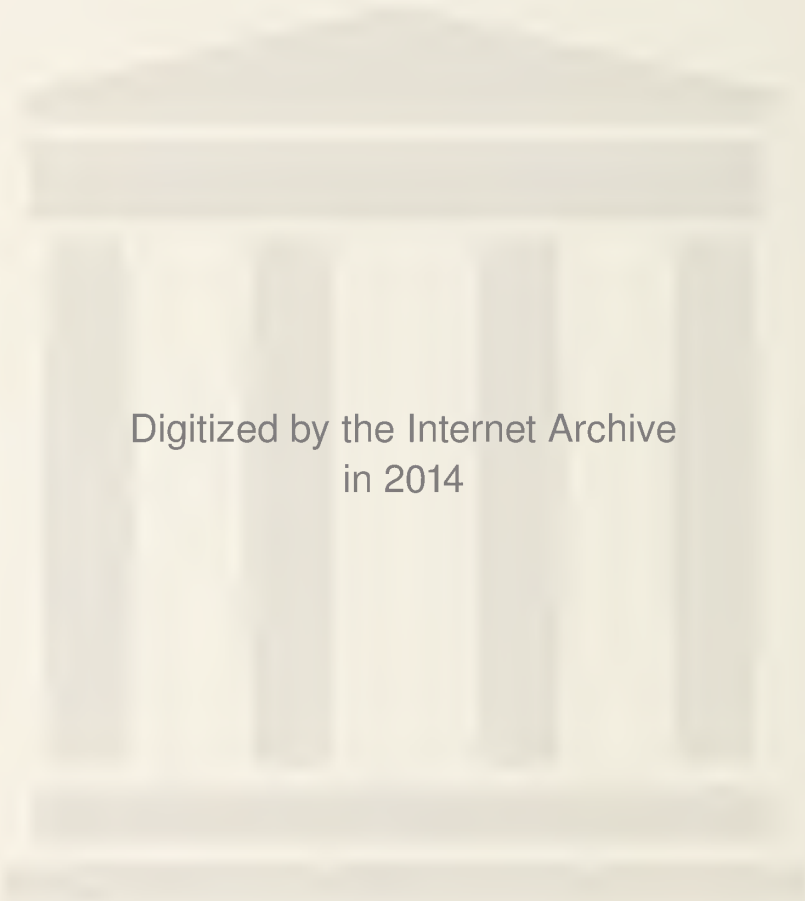

David Nye Barrows, M.D.

ON THE morning of January 28, 1965, Dr. David Nye Barrows passed away in The New York Polyclinic Hospital after a short illness. He was 77 years of age.

Dr. Barrows was born in a medical family in New York City. There was never any question what he wanted to do. He attended St. Paul's School, went on to graduate from Yale in 1908 and from Cornell Medical College in 1912. His life interest in gynecology began on the second (Cornell) division at Bellevue Hospital under his father Dr. C. C. Barrows who was the Attending Gynecologist.

Formerly Clinical Professor of Obstetrics and Gynecology at New York University College of Medicine, Director of Gynecology and later Dean of The New York Polyclinic Medical School and Hospital. He was Attending Gynecologist to Willard Parker Hospital. He was a Consultant in Gynecology and Obstetrics at Bellevue and Polyclinic hospitals, Consultant Gynecologist at Knickerbocker, St. Francis, and Hospital for Special Surgery, and a member of the Courtesy Staff of The New York Lying-In Hospital.

He was Member of the American Medical Association, State and County Medical Societies; Member of the Harvey Society; Fellow of the American College of Surgeons; Diplomate of the American Board of Obstetrics and Gynecology; Fellow of the American College of Obstetricians and Gynecologists; Fellow of the American Association of Obstetricians and Gynecologists; Fellow of the New York Academy of Medicine. He became a member of the New York Obstetrical Society in 1928.

He was a Commander of the New York Chapter of Stars and Bars and Surgeon to the Sons of Confederate Veterans and the Society of Colonial Wars.

The many who had the privilege of knowing David Barrows, the physician, knew and respected his wisdom, common sense and abilities as Obstetrician-Gynecologist. He had the qualities essential for an executive, teacher and preceptor. He was dedicated to his family, profession and colleagues. It would be difficult to appraise how much he had done for the hospitals, interns, residents, patients and friends on the various hospital staffs.

Surviving are his widow, the former Frances Scoville, who is the President of the Ladies' Auxiliary, four daughters, Mrs. Michael Harvan, Lila, Mrs. Henry Bonner and Mrs. Frank Watson, and five grandchildren.

Perry Sanborn Boynton, M.D.

DR. BOYNTON was born in New York City and attended the Collegiate School. He enrolled in Dartmouth College as his father and grandfather had done before him, and like them he pursued a premedical course. He received his Medical Degree from Cornell University Medical College in 1935. While a medical student, he married a classmate, Mary Heiss. The marriage was a happy one, and together they raised three children, all successful in their chosen fields.

After graduation, he pursued the Specialty of Obstetrics and Gynecology at Harlem Hospital and Lenox Hill Hospital. He held the position of Attending Obstetrician and Gynecologist at Lenox Hill Hospital. Dr. Boynton also held a teaching position in the Faculty of Cornell Medical College and was a member of the Attending Staff of The Lying-In-Division of The New York Hospital.

During the Second World War he was an officer in the 12th Evacuation Hospital, the Lenox Hill Unit. He served with distinction overseas. Upon discharge from the Army he returned to private practice in New York City. His life was characterized by hard work and loyal service to patients and to the profession. In recognition of his dedicated service, his peers promoted him quickly to the rank of Attending Obstetrician and Gynecologist in charge of a section of the Service.

Doctor Boynton was active in community affairs. He attended the Brick Presbyterian Church and held the position of Deacon. His life was characterized by his deep religious feelings.

Doctor Boynton was able to combine the best qualities of a dedicated physician with those of a devoted husband and father. His untimely death on Febuary 9, 1965 was a loss to his patients, to the profession, to The New York Hospital-Cornell Medical Center and to his family.

John Randolph Gepfert, Jr., M.D.

DR. GEPFERT was born in Augusta, Georgia, August 26, 1906 and died of a cerebral hemorrhage in The New York Hospital, November 16, 1965 at the age of 59.

He was the son of Dr. John Randolph Gepfert and Georgia Collins Gepfert. His early education was in Augusta, Georgia. He graduated from the University of Georgia at Athens in 1925 and from the University of Georgia Medical College in Augusta in 1929 at the age of 22. After a year's internship in Macon, Georgia, he spent a year as resident in surgery in Macon.

Dr. Gepfert married Meryl Culpepper in 1929 soon after finishing medical school. His wife and two children, John Randolph Gepfert III and Mrs. Richard G. Kopff, survive him.

He came to New York in 1931, spent a year as resident at The New York Lying-In Hospital and two years as resident in Gynecology at Bellevue Hospital. Entering private practice of Gynecology and Obstetrics in 1933, he continued successfully in this field until his untimely death. He was Attending Obstetrician and Gynecologist at Bellevue Hospital from 1933 to 1941, and then became associated with The New York Hospital where he remained until his death, at which time he was an Attending Obstetrician and Gynecologist at The Lying-In Division of The New York Hospital, and Clinical Associate Professor of Obstetrics and Gynecology at Cornell University Medical College.

Dr. Gepfert served in the Medical Corps of the United States Navy from 1943 to 1946, being discharged with the rank of Lieutenant Commander. He was a member of the A.M.A., American College of Surgeons, American Fertility Society, American College of Obstetrics and Gynecology, Lying-In Alumni, Bellevue Alumni and the Union Club.

An early interest in post-operative adhesions and post-operative complications led to Dr. Gepfert's writing several papers on the intraperioneal use of bovine amniotic fluid and on the use of the allantois membrane at the time of tubo-plasty. He was also the author of several other papers. Throughout his life he was interested in tubo-plasties and utilized many different techniques in his endeavor to restore tubal patency.

Dr. Gepfert spent endless hours teaching and training the resident staff in all aspects of Infertility and Obstetrics, always taking advantage of the newer knowledge available or of his own original thinking. Just before his death he became interested in folic acid deficiency in relation to repeated abortions and had secured a gift to undertake research on this problem. A project of this nature is now being carried out in honor of Dr. Gepfert.

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*Until June 30, 1965.

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Cardiology: Robert C. Knapp
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Pulmonary Diseases: George Schaefer
Research on Reproduction: Stewart L. Marcus
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Toxemia of Pregnancy: Robert Landesman
Tumor Service: Tumor Committee
Urology: Thomas F. Dillon

REPORT OF THE OBSTETRICIAN AND GYNECOLOGIST-IN-CHIEF

To the Board of Governors of
THE SOCIETY OF THE NEW YORK HOSPITAL

GENTLEMEN:

I have the honor of presenting herewith the 167th Annual Report of The Lying-In-Hospital of the City of New York for the year 1965. This is my first report and the 34th report prepared since the present physical facilities were opened for patient care on September 1, 1932.

Statistics:

Total discharged patients, including newborn, numbered 12,979 during the year as compared with 13,434 in 1964. Adult discharges were 8,373; 320 less than in the previous year, a decrease of 3.7 per cent. Of these, 5,623 were obstetrical and 2,750 were gynecological patients. Total private-semiprivate discharges constituted 56.1 per cent. The proportion of pavilion obstetrical discharges decreased from 50.8 per cent in 1964 to 50.0 per cent in 1965. The proportion of pavilion gynecological discharges decreased slightly from 31.8 per cent in 1964 to 31.6 per cent in 1965.

There were 5,080 pregnancies involved among the 5,623 discharged patients from the obstetrical service during the year and 4,557 deliveries, a decrease of 133 compared to 4,690 during 1964. Total live births in Manhattan for the same period numbered 45,896 and accordingly those on our service represent 9.9 per cent of all births in this borough.

Spontaneous abortions (miscarriage) and the premature onset of labor continue to represent the greatest cause of pregnancy wastage. The 523 pregnancies that terminated in abortion represent 10.3 per cent of the total pregnancies. In addition, the 321 pregnancies terminated by premature onset of labor resulting in births of premature babies, represent 6.3 per cent of the total pregnancies. Thus 16.6 per cent of all pregnancies were terminated by spontaneous abortion or premature delivery. The perinatal loss in premature births in 1965 was 24.5 per cent which includes the neonatal loss of 13.2 per cent of prematures born alive.

There were 347 premature infants comprising 7.5 per cent of total births in 1965. Perinatal deaths among premature infants were 85 and constituted 74.6 per cent of the total perinatal deaths.

Of the 5,080 pregnant patients cared for, 3,911 were white (77 per cent), 378 were of Puerto Rican origin (7.4 per cent) and 711 were Negro (14.0 per cent). Other ethnic groups accounted for 80 (1.6 per cent).

The perinatal mortality consisted of 114 of 4,601 infants (including multiple births) weighing 500 or more grams (1.1 lbs.). This represents a total perinatal mortality rate of 2.5 per cent compared to 2.4 per cent in 1964. Only 29 of the deaths were in infants that were of term size (2,500 grams), and 14 occurred in infants weighing 3,000 or more grams (6½ lbs.). There were 31 immature infants (weighing 500 to 999 grams, less than 2.2 lbs.), 6 more in this weight category than in 1964, with two survivors. If the infants under 1,000 grams are excluded, the perinatal mortality for all infants weighing over 1,000 grams was 1.8 per cent for 1965 as compared to 1.9 per cent in 1964. For infants 2,500 or more grams (5½ lbs.), the perinatal mortality was 0.7 per cent compared to 0.8 per cent in 1964.

There were three maternal deaths in 1965, one occurring three days after completion of an induced abortion, thought to be due to endotoxic shock with secondary fibrinolysis. The two other deaths occurred in patients transferred postpartum and postabortum respectively from other hospitals for treatment of renal failure. In the postabortum patient disseminated intravascular coagulation was the cause of death, and in the postpartum patient, glomerulonephritis with bilateral cortical necrosis. Autopsies were performed on these three patients.

The total number of patients who delivered out of wedlock infants was 487 or 10.7 per cent among the 4,557 patients who delivered in 1965. The total number of patients pregnant out of wedlock receiving case work by our Social Service Department in 1965 was 596. Again this year, as in the past eight years, all of the patients living in Dana House, operated by Youth Consultation Service, who delivered in 1965 were delivered at The New York Hospital, 92 in number. Of the 92 pregnancies involved, one was deadborn, one died in the neonatal period and two terminated in miscarriage. In 1965, 164 young women from Inwood House were delivered at The New York Hospital.

Of the 164 babies delivered one was deadborn and three died in the neonatal period. Inwood House is another excellent institution dedicated to the care of young women pregnant out of wedlock, for whose residents we have supplied obstetrical care since earl 1964.

Of the 2,750 patients discharged from the gynecological service, 2,433 were operative cases, 988 of which were classified as major.

Twenty-two deaths occurred among gynecological patients, twenty with the underlying cause of malignant neoplastic disease, one from acute septicemia and cervicitis on the second day after admission, and one three days after major surgery as a result of cardiac arrest occurring during the surgery. Three of the cancer patients who died had major surgery on their final admissions, in two exploratory laparotomy disclosed carcinomatosis, death occurring 11 days and 33 days respectively after surgery. The third patient died 57 days after anterior exenteration, of acute pyelonephritis, septicemia and acute bacterial endocarditis. Another cancer patient had paracentesis only on her terminal admission. The other seventeen patients had no surgery on their final admission. Autopsies were performed on fourteen of these twenty-two patients.

Research Activities:

Dr. Carl G. Beling joined the department in August to establish a laboratory for hormone assays. Dr. Beling comes from the Caroline Institute in Stockholm, Sweden, and has worked out a method for the extraction of estrogen hormones from urine. The laboratory was established temporarily in three rooms in the Wood Building and at the end of the year the laboratory already had a considerable capacity of hormone assays. Several patients have been admitted to the Metabolic Research Pavilion of the Hospital for studies of hormone excretion in high risk pregnancies.

Dr. Roy W. Bonsnes has continued the spectrophotometric analysis of amniotic fluids from Rh-negative isoimmunized pregnant women. Chemical analyses of constituents of amniotic fluid, other than those indicated by spectrophotometric analyses, have also been initiated with particular emphasis on those which theoretically help determine the extent the fetus of the isoimmunized Rh-negative mother is affected. The evaluation of a passive hemagglutination inhibition test for chorionic gonadotropin in

the urine is largely completed. The data are presently being prepared for publication. Some of the analytical data collected in the course of the metabolic studies, particularly those relating to the determination of calcium and magnesium in diet and stool by a dry ash procedure have been collated and are being prepared for publication.

Dr. Myron L. Buchman, assisted by Drs. Masao Nakamoto and Gideon Panter, has been in charge of the Family Planning Program and continued his study of the intra-uterine contraceptive devices (IUCD) which is supported by The Population Council. In the beginning of the year it became evident that the device used at that time, the Birnberg Bow, had a much higher incidence of displacement into the abdominal cavity than other devices currently in use. The use of the device was immediately discontinued and an article describing the first cases has been submitted to provide warnings to other departments. A Danish instrument for location of foreign bodies, The Beolocator, has proven of great value in the work with IUCD and may eventually obviate the need for "tails" on such devices. The number of patients in the family planning clinic is steadily increasing but until the clinic facilities have been reconstructed it will be difficult to establish an "open" family clinic.

During a prior research project to obtain normal hematologic values during pregnancy, Dr. Walter L. Freedman found that many patients with the sickle cell trait (SA hemoglobin) who also had an iron deficiency did not respond to iron therapy during pregnancy. To further evaluate this observation a prospective study was begun and completed in 1965. It was found that the sickle cell trait patient with a normal serum iron value will maintain the same hematologic values as the A hemoglobin patient. The iron deficient pregnant patient with SA hemoglobin on the other hand does not correct the anemia when adequately treated with iron.

Dr. Hortense Gandy presented the results of her studies of the Androgen Levels in Ovarian and Adrenal Venous Plasma at the 6th Pan American Congress of Endocrinology in Mexico City. The method developed by Dr. Gandy is generally considered one of the best available, but as all hormone assays on blood it requires exacting and time-consuming work. It is hoped that it will be possible during the coming year to bring all the hormone studies in the department together in one large hormone laboratory on the seventh floor.

Dr. Robert C. Knapp has directed the Obstetrical Cardiac Clinic and has begun cardio-vascular studies in relation to prematurity. He has also continued his evaluation of heart surgery during pregnancy and made a follow-up study of the patients operated in previous years. On the basis of his experience in the clinic, Dr. Knapp has assisted Drs. Eastman and Hellman in the preparation of a chapter on cardio-vascular disease in pregnancy for a new edition of Williams Obstetrics.

Dr. Robert Landesman, assisted by Miss Kathleen Wilson and a first year medical student, Dale Gottdiener, has continued investigations into the relaxant effects of various agents on isolated human uterine muscle in vitro. Obviously it would be of great importance to have pharmacological agents which could bring the uterus to rest in threatened premature labor. Some of the substances tested have been very promising and soon it should be possible to submit them to clinical testing.

Dr. Stewart L. Marcus has continued his investigations into various aspects of reproductive physiology, infertility, and conception control, under research grants from The Population Council and The Health Research Council. Futher work has been conducted on the mode of action of the intra-uterine contraceptive device and, in particular, on the effect on the function of uterine and tubal muscle and on the ovum transport mechanism. Dr. Marcus has also studied the effects of various contraceptive steroids and of other compounds, such as clomiphene citrate, on uterine muscle function and on ovum transport and survival. Continuing his studies on spermatozoal function, he has elucidated the role of leukocytic infiltration and phagocytosis of spermatozoa as a means of removal of excess spermatozoa from the uterus. He is currently investigating the effect of various hormones and immunosuppressive agents on this leukocytic infiltration. Dr. Cyril C. Marcus has collaborated on a number of these studies and has also continued his evaluation of various therapeutic agents in the management of the habitual aborter. In the Infertility Clinic, a number of clinical studies are being continued and expanded. Dr. Cyril Marcus has also completed an extensive statistical study of twin pregnancy at The Lying-In Hospital which has furnished an up-to-date approach to the management of twin pregnancy and delivery.

Dr. Robert N. Melnick has continued his study on Papanicolaou smears in pregnancy. During the year from November 1, 1964 through October 31, 1965, there were 2,378 new patients

registered in the Ante-Partum Clinic and smears were taken from 2,342. Four patients had Class III smears and one of these was found to have basal cell hyperactivity on biopsy while the work-up on the other three patients was negative. All other prenatal patients had Class I or Class II smears. Thus the study revealed no new case of cancer among our pregnant patients. Since the beginning of the project in 1957, 17,516 patients have been screened and 16 cases of carcinoma-in-situ have been found which corresponded to about one in 1,100 patients. No case of invasive carcinoma was detected.

The Pathology Laboratory has been busy during the year as the following table, comparing the activity in 1965 with that of the preceeding year, will show.

	1964	1965
Total number of obstetrical specimens	1,318	1,307
Total number of gynecological specimens	5,061	5,151
Total number of obstetrical slides	1,706	2,103
Total number of gynecological slides	10,822	12,364
Total number of slides	12,528	14,467
Total number of special stains	20	12

Dr. Elmer E. Kramer continues as the Pathologist with Dr. E. William Davis as the Assistant Pathologist. The residents have, as usual, rotated through the laboratory as pathology residents.

Dr. John T. Queenan has been in charge of the Rh immunized mothers and continued his work on intra-uterine blood transfusion to the fetuses that have erythroblastosis. The technique has been improved during the year and valuable experience gained. A method of prevention of immunization is currently under study of selective patients. In January, Dr. Queenan went over to Copenhagen to investigate together with Dr. Fuchs' former colleagues whether the fetus in mid-pregnancy could absorb erythrocytes from the intestinal canal. If this were the case, blood could be injected into the amniotic cavity instead of into the abdomen of the fetus, but unfortunately this proved not to be the case. The studies did show, however, that the fetus swallows considerable amounts of amniotic fluid as early as the end of the first trimester of pregnancy.

During the year a Tumor Committee was established with Dr. William J. Sweeney as the Chairman. Dr. Sweeney and the Committee is working on recommendations for a standardization

of the work-up and treatment of all forms of genital cancer in women. Members of the Tumor Committee will see all the patients admitted with cancer and give advice as to the optimal form of treatment. Radical surgery still plays a major role in the approach of the early stages of cancer of the uterus.

As the statistics show, prematurity continues to be a serious problem with 70 per cent of the total perinatal deaths occurring in premature infants. During 1965 a study was initiated with an aim to reduce the incidence of prematurity. Previous endeavors aimed at re-enforcement of uterine defense mechanism had been unable to stop threatened premature labor. A different approach is to inhibit the activating forces which stimulate the uterus in labor. The main activating force is assumed to be oxytocin, one of the two neurohypophyseal hormones. It has been shown that alcohol blocks the release of these two hormones, and during the year, a number of cases with threatened premature labor were treated with intravenous alcohol. The study was started by Dr. Robert E. Hardy and continued by Drs. Abraham Risk and Vincente Poblete under the direction of Dr. Fuchs. The results have been very promising, especially in cases with intact membranes. It is too early, however, to say whether this treatment will be able to reduce significantly the incidence of premature birth.

Several other members of the attending staff, often in cooperation with residents, carried out clinical studies and published reports during the year.

Grants:

The Josiah Macy, Jr. Foundation has made a grant to the department for support of education and research on biological and medical aspects of reproduction. The grant will cover a period of five years beginning July 1, 1965 and the total amount is $250,000. The grant will provide salaries for research training in one of the basic sciences, supplemental salaries during residency training for individuals with previous research training in one of the basic sciences, salaries for full-time research positions after such training, salaries for scientists trained in one of the basic sciences, and finally scholarships in reproduction for medical students.

The Population Council has made two grants to the department, one in the amount of $15,000 to the family planning

studies of Dr. Buchman and another in the amount of $13,935 to Dr. Stewart Marcus for studies in reproductive physiology. Dr. Gandy is the recipient of NIH grants totalling $56,572 for her studies of androgen metabolism.

The Health Research Council of the City of New York has made a 3-year grant in the amount of $37,882 for Dr. Marcus' studies in reproductive physiology, and continued the support of Dr. Queenan's work for a fourth year.

Grants in support of various research activities have been received from the USPHS General Research Support Grant, from Sandoz Pharmaceuticals, The Massengill Company, Mead Johnson Laboratories, the Smith Kline & French Foundation, as well as from private donors. All these grants are gratefully acknowledged.

Staff Changes:

Dr. R. Gordon Douglas has been appointed Emeritus Professor of Obstetrics and Gynecology. During the year he completed with the aid of Dr. Nakamoto the second edition of his and Dr. Stromme's book "Operative Obstetrics." Dr. Douglas gave a lecture at one of the joint Obstetric-Pediatric Staff Meetings in May on his new assignment with the Maternal and Child Health Program of the New York City Department of Health. It is fortunate that Dr. Douglas remains in New York and will make his great experience available for the Department.

Dr. Ralph W. Gause has assumed the position as Director of Obstetrics and Gynecology at The Roosevelt Hospital, but still remains connected with this Department. Dr. Nakamoto left the Department in July to assume the position as Director of Obstetrics at White Memorial Medical Center in Los Angeles. Dr. Robert E. Hardy and Dr. Daniel W. Adams completed their five year resident training; Dr. Hardy went into practice in Cambridge, New York, and Dr. Adams went to fulfill his military obligations. Drs. Gladstone, Engel, Terry and Livingston completed their three year resident training, and Dr. Livingston remained on the staff as an Assistant Attending and Clinical Instructor. Dr. Irwin Merkatz, a former resident, joined the Department in July as a Macy Foundation Fellow to work with Dr. Beling in the hormone laboratory. Dr. Gideon G. Panter and Dr. Vincent duVigneaud Jr., both Cornell graduates, joined the Attending Staff after completion of their residencies at the

Sloane Hospital for Women and the Roosevelt Hospital, respectively. Two members of the staff, Drs. Mann and Langstadt, were on leave of absence during the year because of illness.

It is a real pleasure to express my sincere appreciation to all workers in the department whose loyal devotion to their duties has made it possible to continue to render high quality care to our patients and to secure continuation of department function in spite of the change in direction. I am grateful for valuable assistance from Dr. Joseph C. Hinsey, Director of The New York Hospital-Cornell Medical Center; Dr. Henry N. Pratt, Director of The New York Hospital; Dr. John E. Deitrick, Dean of Cornell University Medical College; Dr. August H. Groeschel, Associate Director of The New York Hospital; Mr. Ernest F. Gamache, Secretary of The Society of The New York Hospital; and Mr. Edward K. Taylor, Business Manager of Cornell University Medical College.

The staff is most thankful to the Board of Governors of The Society of the New York Hospital and to the Ladies' Auxiliary to The Society of the Lying-In Hospital for their continued and generous support.

Respectfully submitted,

Fritz Fuchs, M. D.
Obstetrician and Gynecologist-in-Chief

REPORT OF THE HEAD OF OBSTETRICAL AND GYNECOLOGICAL NURSING SERVICE

To the Board of Governors of

The Society of the New York Hospital

Gentlemen:

I have the honor to present the Annual Report of the Nursing Service and Nursing Education for the year 1965.

Administration:

Miss Julia M. Dennehy, Department Head, Obstetrics and Gynecology, became Assistant Director, Nursing Service, in September 1965. She was replaced as Department Head by Miss Anne T. Lally.

The core group of supervisors remained essentially the same, and continuity in service and educational offerings was maintained.

Staffing:

The issue of "shortage" in staff, particularly in professional nurse staff, became and remained the key problem in the entire department during 1964—1965. As a result M-4 remained closed from June 14 to October 21. As the professional staff became fewer (82 as against 120) the pressure of utilizing the remaining nurses on evening and night relief posed many hardships. Toward the end of the year, the outlook for increasing the nursing staff seemed better.

Utilization of Personnel:

In order to best utilize all levels of persons ministering to our patients, efforts were made to increase the effectiveness of non-professional persons. Additional duties were delegated to licensed practical nurses within their scope of preparation. The nurses' aides were utilized to participate much more actively in giving care of a limited scope to patients who would benefit from such assistance.

The introduction and continued use of disposables, such as admission sets, proctoscopy, etc., was very effective in saving time, which in turn was devoted to patient care.

A messenger service for the Department has also been initiated. It has contributed in no small manner to saving time lost by nursing personnal in errands and transportation of patients.

Renovation and Equipment:

Two units, M-4 and M-5, were painted and several minor renovations, such as lighting, etc., were instituted.

In October M-4 became a semi-private unit for gynecological patients, while pavilion patients were cared for on M-5.

The addition of new equipment, autoclave, hi-low beds, formula refrigerator, has definitely conserved time because of fewer engineering breakdowns.

Educational Programs:

1. Preparation for Labor: Of the 4,551 mothers who had their infants born in New York Hospital in 1965, the following groups attended classes:

768 Mothers
354 Fathers
283 Couples

2. Classes on infant care and breast feeding were offered continuously during the year. These continue to be very popular with mothers. Moreover a formula preparation demonstration class is offered several times weekly to interested mothers.

3. Nursing Education: During the academic year, approximately 22 Cornell University nursing students every 9 weeks availed themselves of the obstetrical learning experiences.

Gynecological units also continue to be used as a setting for senior nursing students during their team leadership experiences.

4. The demand for observation and experience in the Department by persons from other countries and innumerable agencies continues. Although this, at times, is very time consuming, the staff willingly makes great efforts to accommodate. Rooming-In continues easily as the greatest area of demand in this respect.

5. Staff Development: It is becoming increasingly evident that the best utilization of our nursing resources in Lying-In demands continuous staff education and development. One supervisor devotes full time to this effort, and has begun programs to reach each level of worker in the Department. For example, in order to carry through the philosophy of the institution in Labor

and Delivery, it becomes essential to orient and teach each new nurse that most of our mothers participate actively in their labor and delivery. Coming, as nurses do, from varying backgrounds, it takes planned time to enable them to teach mothers how to utilize breathing exercises as labor progresses. This, in turn, has to be applied to all other units in the Department.

Representatives from each unit were enabled to attend outside meetings on a planned basis. The sharing of this experience was utilized in the growth of personnel. Seminars, panels, institutes, were thus utilized.

6. Revision of Manuals: The procedure manuals for each unit are a distinct teaching device. These were revised and updated, and used in the orientation of new personnel.

Interdepartmental Relationships:

1. Liaison Meetings: In an effort to improve and actively promote better doctor-nurse relationships in the Department, liaison meetings were initiated. These are held as indicated, at least monthly, and have noticeably improved mutual understanding.

2. Interdepartmental representatives of other departments are invited to meet and discuss with supervisory personnel, ways and means to seek mutual cooperation in the better interests of patient care.

On behalf of nursing service in this department, I would like to express my sincere thanks and appreciation to Dr. Fritz Fuchs, our new Obstetrician-and Gynecologist-in-Chief for his active support of our efforts to improve patient care. During this period of change, it has been a rewarding experience to work with him in further developing the goals of the department.

Respectfully submitted

Anne T. Lally
Department Head

LADIES' AUXILIARY

TO

THE SOCIETY OF THE LYING-IN HOSPITAL

1966

OFFICERS

Mrs. David N. Barrows . . . . . *President*

Mrs. J. Culbert Palmer . . . . . *Vice-President*

Mrs. Paul Pryibil . . . . . *Treasurer*

Mrs. Graham G. Hawks . . . . . *Assistant Treasurer*

Mrs. Randolph Gepfert . . . . . *Corresponding Secretary*

Mrs. Elmer E. Kramer . . . . . *Recording Secretary*

REPORT OF THE LADIES' AUXILIARY

To the Board of Governors of

THE SOCIETY OF THE NEW YORK HOSPITAL

GENTLEMEN:

I have the honour of presenting to you the Annual Report of the Ladies' Auxiliary to the Society of the Lying-In Hospital.

First of all mention must be made of the hours of enthusiastic and dedicated service given by Mrs. J. Culbert Palmer and her Committee in furthering the Bablies' Alumni. 921 new members were enrolled this year bringing the total membership to 3,617. Dues from these Alumni come from near and far—South Africa, Australia, South and Central Americas and Europe as well as all parts of the United States. Besides the $10,192 added to our Treasury, we feel that this is an important Public Relations factor for the Lying-In. Our thanks go to this hard working committee and also to the ladies who address the hundreds of birthday cards.

The Babies' Class, under the able Chairmanship of Mrs. Graham Hawks, enrolled 16 new members making a total membership of 208 and an income of $540.

Through the efforts of Mrs. Kinzel, the supply of layettes has been increased by contributions from various Church groups, of hand made articles as well as the necessary diapers, shirts and nightgowns.

Radio Station WOR contributed 108 layettes for distribution at Christmas time, for which we express our gratitude.

We are also grateful to the Danziger Fund for their grant of $200 for orthopedic appliances.

As usual we participated in the United Hospital Fund Campaign raising $5,732 including Box Week.

Our finances have, as for many years past, been most efficiently handled by Mrs. Pryibil. It would be impossible for us to function without her loyalty and support.

The Social Service Department has given outstanding service to many patients under the able leadership of Miss Jonas and Mrs. Kurtz. We thank them for their efforts and also for giving interesting reports and case presentations at our meetings.

The Board of Governors has, as always, given us their full backing financially and otherwise, for which we are most grateful.

In ending, I must again express my appreciation, admiration and gratitude to all members of the Board for their unfailing loyalty, efficiency and support.

Respectfully submitted,
FRANCES S. BARROWS
President

REPORT OF THE CASEWORK SUPERVISOR OF OBSTETRICAL AND GYNECOLOGICAL UNIT SOCIAL SERVICE DEPARTMENT

To the Board of Governors of

The Society of the New York Hospital

Gentlemen:

The mid point of a decade invites one to look at the statistical data of the work of the Social Service Department in Obstetrics and Gynecology for the past five years. This examination of statistical data reveals several interesting trends. Apart from 1964 when there was a slight increase in the number of patients referred to the Social Service Department, the trend over the past five years has been one of a decreasing number ranging from 1061 new referrals in 1961 to 769 in 1965. As the number of new referrals has decreased the total number of interviews and supporting services have increased thereby increasing the amount of casework service per patient. This statistical evidence demonstrated the fact that we are succeeding in our efforts to provide a more meaningful professional service to this group of patients who, by and large need a helping service which goes beyond a single interview or two.

There are several possible explanations for these statistical trends. The decrease in referrals appears to be reflecting the general decrease in the number of patients coming to the Lying-In Hospital, especially for obstetrical care. Our continuing efforts to avoid duplicating services to patients who are receiving social services from community agencies has resulted in some decrease in our volume of cases but has released time to the caseworkers to devote to patients who are not receiving service from other sources. For two years a considerable volume of time consuming social service activity, such as liaison with community agencies and details of arranging for discharge of infants to child placing agencies has been assumed by the case aide who has been borrowed from the Table of Organization of the Main Hospital Social Service. Inasmuch as the case aide services have not been included in the statistics for Lying-In, there has been a substantial increase in total social service activity to patients in Lying-In.

One of the most satisfying developments to report for 1965 is the addition of regularly scheduled psychiatric consultation to the casework staff in Lying-In. Since June, Dr. Stuart Edelson, a member of the Payne Whitney staff who is especially interested in the study of unmarried mothers has been providing consultation for a two hour period each week. Although this is still a relatively new experience for us, the social work staff has already benefited from the increased understanding of the psychodynamics of the behavior of patients with whom they are working and this, we are sure, is being reflected in more effective help which is being given to a selected group of our patients and their families. As an outgrowth of these consultations we are beginning to collect data which we hope will contribute to our knowledge of the psycho-social problems of out-of-wedlock pregnancies. Our special interest has been the mothers who keep their babies, many of whom neither seek nor receive services from the community but for whom hospital connected services are their primary source of help. Our data are showing that a large percentage of these patients, from all socio-economic backgrounds have had chaotic lives and serious problems in multiple areas of social adjustment. Our concern is to provide assistance which can help them to establish some stability in their lives to enable them to provide a more favorable environment for the child.

We are again fortunate to have completed the year without any turnover in professional or clerical staff. Credit for this situation can be attributed to several factors: a demanding but stimulating ambiance in which to work, congenial colleagues and good personnel practices.

Again we wish to express our thanks to co-workers in the hospital and in the community for their help throughout the year. We are also grateful to Dr. Fuchs, the Hospital Administration and the Ladies Board for their support in our activities.

Respectfully submitted,

(Mrs.) Elizabeth J. Kurtz
Casework Supervisor

DISTRIBUTION OF BEDS

OBSTETRICAL	*Adult*	*Bassinets*
Private	16	16
Semiprivate	33	31
Pavilion	70	60
Total	119	107
GYNECOLOGICAL		
Private	10	
Semiprivate	26	
Pavilion	44	
Total	80	
Total Adult Beds	199	
Total Bassinets	107	
Total	306	

DISCHARGES

OBSTETRICAL (Adults)			
Private	655		
Semiprivate	2,159		
Pavilion	2,809	5,623	
GYNECOLOGICAL			
Private	398		
Semiprivate	1,482		
Pavilion	870	2,750	8,373
NEWBORN			4,601
INFANT BOARDERS			5
Total			12,979

SUMMARY OF
OBSTETRICAL AND GYNECOLOGICAL SERVICES
September 1, 1932—December 31, 1965

TOTAL NUMBER	
*Obstetrical adult patients	161,737
*Infants	133,265
Gynecological patients	61,274
Grand Total	356,276

*Includes John E. Berwind Free Maternity Service operated by this department from September 1, 1932 to May 1, 1942.

STATISTICS

OBSTETRICAL DEPARTMENT

January 1, 1965—December 31, 1965

TOTAL DISCHARGES	*Number*	*Per Cent of Adult Discharges*
†*Abortion, operative	463	8.2
Abortion, spontaneous	32	0.6
Premature operative delivery	142	2.5
Premature spontaneous delivery	179	3.2
Full term operative delivery	1,618	28.8
Full term spontaneous delivery	2,618	46.6
Ectopic pregnancy (26 tubal)	26	0.5
Hydatidiform mole (Intermediate)	1	0.02
Chorionepithelioma	1	0.02
Discharged before delivery	436	7.7
Postpartum (within 6 weeks)	84	1.5
Postpartum (after 6 weeks)	23	0.4
Infant boarders	5	
Total	5,628	

ETHNIC GROUP (Pregnancies)	*Number*	*Per Cent*
Puerto Rican	378	7.4
Nonwhite	791	15.6
Other	3,911	77.0
Total	5.080	100,0

PRESENTATION (Full Term and Premature Deliveries)	*Number*	*Per Cent*
Vertex	4,345	95.3
Breech	178	3.9
Brow	6	0.1
Face	3	0.1
Transverse	15	0.3
Compound	3	0.1
Oblique	4	0.1
Not Known	3	0.1
Total	4,557	100.0

*In this report weight is the standard for classification of infants as follows:

	Weight in Grams
Abortion	Less than 500
Premature infant	500–2,499
Full Term infant	2,500 and over

†There were four additional fetal deaths under 500 grams to the total abortions in this table. Two represented the second of twin abortions, the other two second twins of abortion weight, where the other twin weighed over 500 grams.

OPERATIONS (Full Term and Premature Deliveries)	*Number*		*Per Cent of Total Deliveries*	
Forceps				
Low	577		12.6	
Low-Mid	602		13.2	
Mid	128		2.8	
High	4	1,311	0.1	28.8
Failed forceps, delivered spontaneously	1		0.02	
Forceps, rotation instigated only	5		0.1	
Breech with forceps to after-coming head (31 assisted, 2 extraction)	34		0.7	
Breech extraction (10 with MSV maneuver)	17		0.4	
Decomposition and breech extraction with Prague maneuver	1		0.02	
Breech with MSV maneuver	2		0.04	
Assisted breech with MSV maneuver	72		1.6	
Assisted breech	10		0.2	
Conversion of shoulder dystocia and manual delivery of infant	1		0.02	
Version and extraction (1 "B" twin)	3		0.06	
Vacuum extraction	2		0.04	
Manual removal of placenta	69		1.5	
Cesarean Section				
Classical	9		0.2	
Low cervical	220		4.8	
Radical (hysterectomy)	1		0.02	
High transverse	1		0.02	
Low transverse	1	232	0.02	5.1
TOTAL OPERATIVE DELIVERIES		1,760		38.6
Episiotomy		3,359		73.7
Episiotomy with third degree extension incomplete		166		3.6
Episiotomy with third degree extension complete		167		3.7
Repair of third degree laceration, incomplete		22		0.5
Repair of third degree laceration, complete		21		0.5

INDICATIONS FOR CESAREAN SECTION	*Number*		*Per Cent of Cesarean Sections*	
Contracted Pelvis and Mechanical Dystocia				
Fetopelvic disproportion (11 breech)	39		16.8	
Presentation (9 transverse, 1 oblique lie)	10		4.3	
Primiparous breech with lack of progress	4		1.7	
Lack of progress	4		1.7	
Previous Shirodkar procedure	10		4.3	
Previous vaginal plastic operation	2		0.9	
Dystocia due to tumor (obstructing myoma)	1		0.4	
Myomata uteri and hypertension	1		0.4	
Cervical dystocia	1	72	0.4	31.0
Previous cesarean section	95		40.9	40.9
Previous myomectomy	3		1.3	1.3
Previous hysterotomy and uterine scar defect	1	99	0.4	0.4
Hemorrhage				
Placenta previa	7		3.0	
Premature separation of placenta	9		3.9	
Placenta previa and premature separation of the placenta	1		0.4	
Third trimester bleeding	1	18	0.4	7.8
Intercurrent Disease				
Diabetes	1	1	0.4	0.4
Severe preeclampsia	1	1	0.4	0.4
Miscellaneous				
Elderly primipara	16		7.0	
Prolapsed cord	5		2.2	
Fetal distress	16		7.0	
Failed forceps	1		0.4	
Amnionitis (PRM 9 days)	1		0.4	
Poor obstetrical history	1		0.4	
Abdominal pain, undetermined etiology	1	41	0.4	17.8
Total Indications		232		100.0

INCIDENCE OF CESAREAN SECTION

	Per Cent
Total	5.1
Private	7.3
Pavilion	3.0

OBSTETRICAL COMPLICATIONS

	Number	*Per Cent*
IN TOTAL DELIVERIES		
Placenta previa and premature separation of placenta	1	0.02
Placenta previa	17	0.4
Premature separation of placenta	47	1.0
Suspected marginal sinus rupture	3	0.1
Placenta accreta	1	0.02
Couvelaire uterus	1	0.02
First trimester bleeding	327	7.2
Second trimester bleeding	78	1.7
Third trimester bleeding	128	2.8
Rupture of uterus, spontaneous	1	0.02
Rupture of uterus, (previous Cesarean Section)	1	0.02
Rupture of uterus incomplete (previous Cesarean Section)	2	0.04
Defects in previous uterine scars	9	0.2
Postpartum hemorrhage (Cesarean Section excluded)	59	1.4
Postpartum hemorrhage (Cesarean Section included)	114	2.5
Puerperal bleeding	66*	1.4
Contracted pelvis or borderline pelvis	99	2.2
Prolonged labor	20	0.4
Prolapsed cord	18	0.4
Fetal distress	280	6.1
Incarcerated uterus	1	0.02
Uterine dysfunction	14	0.3
Probable fracture of coccyx during delivery	1	0.02
Peroneal nerve palsy unknown etiology second trimester	1	0.02
Muscle strain	4	0.1
Separation of sacroiliac joint	1	0.02
Premature rupture membranes (more than 24 hrs. prior to onset of labor)	123	2.7
Rupture of Bartholin's duct cyst at delivery	1	0.02
IN TOTAL PREGNANCIES (Deliveries and Abortions)		
Toxemia Total	233	4.6
Severe preeclampsia	33	0.6
Mild preeclampsia	149	2.9
Hypertensive disease and severe preeclampsia	6	0.1
Hypertensive disease and mild preeclampsia	10	0.2
Hypertensive disease and unclassified	1	0.02
Hypertensive disease	27	0.5
Renal disease, hypertensive disease and mild preeclampsia	1	0.02
Renal disease and mild preeclampsia	4	0.1

*Includes 44 postpartum admissions, whether or not delivered here.

OBSTETRICAL COMPLICATIONS—*Continued*

IN TOTAL PREGNANCIES (Deliveries and Abortions)—*Continued*	*Number*	*Per Cent*
Unclassified	2	0.04
Antepartum infection (fever of undetermined origin)	3	0.1
Intrapartum infection (33 among abortions)	69	1.4
Febrile postpartum course	108	2.1
—puerperal infection	69	1.4
—mastitis	5	0.1
—pyelitis	2	0.04
—intercurrent (10 urinary, 2 atelectasis, 7 other respiratory, 2 gastroenteritis, 1 meningitis, 1 viral infection, 1 subphrenic abscess)	24	0.5
—other (2 ileus, 1 wound infection, 3 hematoma, 1 probable reabsorption of blood in ruptured ectopic, 1 transfusion reaction)	8	0.2
One day fever	183	3.6
Antepartum breast abscess	1	0.02
Non-suppurative mastitis	1	0.02
Anemia		
Antepartum (Ht. 35 or less, Hgb. 11 or less without diagnosis of specific anemia)	1,002	19.7
Postpartum (Ht. 35 or less, Hgb. 11 or less)	989	19.5
Thrombophlebitis		
Antepartum	15	0.3
Postpartum (includes 2 P.P. admissions)	40	0.8
Hydramnios	24	0.5
Peritonitis	2	0.04
Small bowel obstruction	1	0.02
Paralytic ileus	10	0.2
Septicemia (8 in abortions, 2 in deliveries)	10	0.2
Pulmonary embolism, or infarction	6	0.1
Cardiac arrest and death, ? endotoxic shock, postabortal	1	0.02
Hypotension or shock	22	0.4
Transfusion reaction, mild	6	0.1
Others	167	3.3

SELECTED ANTEPARTUM AND CONCURRENT CONDITIONS

IN TOTAL PREGNANCIES (Deliveries and Abortions)—*Continued*	*Number*	*Per Cent*
GYNECOLOGICAL		
History of carcinoma of cervix in situ	3	0.1
Carcinoma of cervix in situ	1	0.02
Carcinoma of ovary (postoperative, 1960)	1	0.02

SELECTED ANTEPARTUM AND CONCURRENT CONDITIONS— *ontinued*

IN TOTAL PREGNANCIES (Deliveries and Abortions)—*Continued*	*Number*	*Per Cent*
Incompetent cervical os	8	0.2
Congenital malformation of genital organs	24	0.5
Other gynecologic disease	1,592	31.3
MEDICAL (Except Gynecological Disease)		
Circulatory		
Heart disease	80	1.6
Potential or probable heart disease	16	0.3
Valvulotomy, antepartum	1	0.02
Previous valvulotomy	2	0.04
Previous repair of congenital defects of heart	7	0.1
Previous portocaval shunt	2	0.04
Other circulatory	463	9.1
Respiratory		
Tuberculosis, pulmonary (active 2, inactive 54, questionable 7)	63	1.2
Other respiratory diseases	336	6.6
Digestive		
Appendicitis	5	0.1
Ulcerative colitis or history of	5	0.1
Infectious hepatitis (1 questionable, 1 atypical)	3	0.1
Hepatitis, undetermined etiology	1	0.02
Jaundice, undetermined etiology	1	0.02
Jaundice secondary to postnecrotic cirrhosis	1	0.02
Abscess of spleen with infarct and non-specific reactive hepatitis	1	0.02
Other digestive diseases	157	3.1
Urinary		
Chronic renal disease	14	0.3
Acute glomerulonephritis	1	0.02
Anomaly of kidney, ureter, or bladder	9	0.2
Pyelitis, antepartum	12	0.2
Other urinary tract infection	119	2.3
Other urinary	79	1.6
Blood and Blood-Forming Organs		
Iron deficiency anemia	534	10.5
Sickle cell anemia, trait	12	0.2
Folic acid deficiency anemia	2	0.04
Thalassemia minor	13	0.3
Others of blood and blood-forming organs	21	0.4

SELECTED ANTEPARTUM AND CONCURRENT CONDITIONS—*Continued*

MEDICAL (Except Gynecological Disease) —*Continued*	*Number*	*Per Cent*
Endocrinological and Nutritional		
Stein-Leventhal syndrome	5	0.1
Chiari-Frommel syndrome (past history in one)	2	0.04
Diabetes (18 possible, or latent)	32	0.6
Diabetes secondary to Whipple procedure	1	0.02
Thyrotoxicosis	1	0.02
Hyperthyroidism	6	0.1
Hypothyroidism	13	0.3
Hypoparathyroidism	1	0.02
Other endocrinological and nutritional	149	2.9
Mental, Nervous, and Sense Organs		
Mental disease	49	1.0
Epilepsy	12	0.2
Neurosis, anxiety	35	0.7
Other nervous	49	1.0
Diseases of the eye and ear	40	0.8
Cancer and Other Tumors		
Malignant melanoma of back surgically treated, antepartum	1	0.02
Carcinoma of the breast, post radical mastectomy and chemotherapy	1	0.02
Hodgkin's disease (2 active)	4	0.1
Carcinoma of hard palate with metastasis to face (current)	1	0.02
Carcinoma of kidney post nephrectomy	1	0.02
Carcinoma of thyroid postoperative	1	0.02
Malignant melanoma postoperative (thigh 1, leg 1)	2	0.04
Chondrosarcoma of femur, post hemipelvectomy, 1957	1	0.02
Leiomyosarcoma of duodenum, postoperative 1953	1	0.02
Carcinoma skin of shoulder, postoperative	1	0.02
Lymphoepithelioma of nasopharynx, post-radiation, 1957	1	0.02
Benign tumors	102	2.0
Skin Diseases	92	1.8
Bone and Muscle Diseases	103	2.0
Miscellaneous		
Rubella (including 5 "exposed to rubella")	20	0.4
Chicken pox	1	0.02
Mumps	6	0.1
Gonorrhea	8	0.2
Syphilis or history of syphilis	35	0.7
History of drug sensitivity	569	11.2
Other miscellaneous	8	0.2

SURGERY COMPLICATING PREGNANCY

DURING PREGNANCY

Myomectomy	1
Oophorectomy	2
Salpingectomy	1
Resection of ovarian cyst	3
Ovarian cystotomy and biopsy	1
Cholecystectomy	1
Splenectomy with drainage	1
Appendectomy for appendicitis	4
Cecostomy and drainage of ruptured appendix	1
Incidental appendectomy	2
Exploratory laparotomy	1
Secondary closure of abdominal wound dehiscence	1
Repair of incompetent cervix (Shirodkar procedure)	13
Removal of cervical sutures (Shirodkar)	3
Release of incarcerated uterus and insertion of pessary	1
Colpotomy	1
Culdocentesis	3
Cervical polypectomy	2
Vaginal polypectomy	1
Conization of cervix (Dec. 1964, del. in 1965)	1
Biopsy of cervix	5
Lysis of congenital vaginal band during labor	1
Splint of fracture of elbow	1
Splint and ace bandage applied to fracture of finger	1
Reduction of fracture and fixation of mandible	1
Excision of scar of lower leg	1
Transabdominal amniocentesis and instillation of dextrose in case of intrauterine death for induction of labor	1
Transabdominal amniocentesis (patients)	27
Intrauterine transfusion (patients)	12
Marsupialization of Bartholin's duct cyst	1
Incision and drainage of labial abscess	1
Fulguration of condylomata	1
Excision of granuloma of labia	1
Insertion of pessary	1
Removal of pessary	2
Excision of benign breast tumors	9
Incision and drainage of abscess of axilla	1
Excision of rectal polyp	1
Incision and drainage abscess of thigh	1
Incision and drainage of perirectal abscess (repeated)	2
Incision and drainage of pilonidal cyst abscess	1
Incision and drainage of chalazion	1
Excision of malignant melanoma of back and skin graft	1
Thyroidectomy	1
Excision neurilemmona of neck	1
Valvuloplasty	1
Suturing of laceration of scalp	1

SURGERY COMPLICATING PREGNANCY— *ontinued*

DURING PREGNANCY—*Continued*

Excision pyogenic granuloma of gingiva	1
Tonsillectomy	3
Irrigation of antrum (under anesthesia)	1
Cauterization nasal septum	1
Myringotomy for ear infection	1
Bone marrow biopsy	10
Scalene node biopsy	2
Liver biopsy	5
Skin and muscle biopsy	1
Axillary node biopsy	1
Aspiration of left knee	1
Excision of nevi or other benign tumors	21
Tooth extraction	16
Esophagoscopy and gastroscopy	1
Excision of ganglion of wrist	1
Total	188

AT TERMINATION OF PREGNANCY

AT CESAREAN SECTION

Hysterectomy (total)	1
Myomectomy	3
Repair of uterine defect	2
Repair of ruptured uterus	1
Repair of bladder rent	1
Lysis of adhesions	3
Appendectomy	19
Tubal sterilization	21
Excision of old abdominal scar	3
Excision of umbilical nevus	1
Total	55

AT VAGINAL DELIVERY

Cervical repair	86

IN THE POSTPARTUM PERIOD

Total abdominal hysterectomy	1
Exploratory laparotomy and other procedure	5
Tubal sterilization, 11 transvaginal (5 with cryosurgery), 7 abdominal	18
Dilation and curettage	69
Tamponade of uterus	10
Removal of placental fragments	4
Secondary repair of episiotomy	17
Evacuation of hematoma (vaginal)	14
Other operations	104
Total	242

SURGERY COMPLICATING PREGNANCY—*Continued*

NON-OPERATIVE PROCEDURES AMONG PATIENTS WHO DELIVERED

	Number	*Per Cent of Total Deliveries*
Induction with pitocin alone	333	7.3
Induction—rupture of membranes alone	3	0.1
Induction with pitocin and rupture of membranes	112	2.5
Induction—rupture of membranes and stimulation with pitocin	13	0.3
Stimulation of labor with pitocin alone	887	19.5
Vaginal examination—intrapartum	4,360	95.7
Exploration of uterine cavity at delivery	230	5.0
Proctoscopy	3	0.1
Transfusions (number of patients receiving transfusions*)	59	1.3

ANTEPARTUM DISCHARGES

PRIMARY REASON FOR ADMISSION

	Number	*Per Cent of Antepartum Discharges*
OBSTETRICAL COMPLICATIONS		
False labor	87	19.9
Antepartum bleeding (1st trimester, 11; 2nd, 12; 3rd, 37)	60	13.8
Threatened abortion	47	10.8
Premature rupture of membranes, or question of	14	3.2
Premature labor	18	4.1
Premature effacement of cervix	1	0.2
Evaluation after Shirodkar procedure	1	0.2
Failed induction	3	0.7
Toxemia or suspected toxemia	14	3.2
Other obstetrical complications	37	8.5
GYNECOLOGICAL COMPLICATIONS		
Operative	42	9.6
Non-Operative	12	2.8
MEDICAL AND SURGICAL COMPLICATIONS (Excluding Gynecological Disease)		
Operative	9	2.1
Non-Operative		
Evaluation of esophageal and gastric varices and jaundice (post portocaval shunt in 1962)	1	0.2

*The total number of obstetrical patients receiving transfusions was 118.

ANTEPARTUM DISCHARGES—*Continued*

MEDICAL AND SURGICAL COMPLICATIONS —*Continued*	*Number*	*Per Cent of Antepartum Discharges*
Acute rheumatic fever and evaluation of cardiac status (one patient)	2	0.5
Pre and post valvulotomy evaluation (2 admissions for one patient)	3	0.7
Pneumonia	2	0.5
Other non-operative complications	83	19.0
TOTAL	436	100.0

POSTPARTUM ADMISSIONS

PRIMARY REASON FOR ADMISSION

	Number	*Per Cent*
Puerperal bleeding, dilatation and curettage performed (secondary repair of episiotomy in 2, and biopsy of cervix in 7)	32	29.9
Puerperal bleeding, other	10	9.3
Dilation and curettage, tamponade of uterus and secondary repair of episiotomy (in 4)	8	7.5
Febrile due to:		
puerperal infection	7	6.5
mastitis	2	1.9
pyelitis	1	0.9
Endometritis, parametritis (3 with one day fever)	5	4.7
Other	42	39.3
TOTAL	107	100.0

PERINATAL MORTALITY BY CAUSE OF DEATH, TIME OF DEATH AND BY BIRTH WEIGHT—1965

Cause of Death*	Before Labor				During Labor				Neonatal				Total			
	500-999	1000-2499	2500+	Total	500-999	1000-2499	2500+	Total	500-999	1000-2499	2500+	Total	500-999	1000-2499	2500+	Total
Anoxia																
Premature separation of the placenta	..	1	1	2	1	..	1	2	1	..	1	2	2	1	3	6
Other placenta	..	4	1	5	1	1	..	2	..	..	..	..	1	5	1	7
Cord prolapse	..	..	..	..	..	1	..	1	..	1	..	1	..	2	..	2
Cord—other	2	2	..	4	1	2	2	5	..	..	..	..	3	4	2	9
Anoxia	..	..	1	1	..	1	..	1	..	1	..	1	..	2	1	3
No Abnormal State—Maternal Complication																
Toxemia	3	1	..	4	..	..	..	..	..	..	..	..	3	1	..	4
Diabetes	..	..	..	..	..	..	..	..	1	..	1	2	1	..	1	2
Intrapartum infection	1	..	..	1	1	1	..	2	1	..	..	1	3	1	..	4
Recent surgery for ruptured appendix	..	..	..	..	..	..	..	..	1	..	..	1	1	..	..	1
Antepartum bleeding	2	1	..	3	1	..	..	1	2	..	..	2	5	1	..	6
Malformation	1	..	..	1	..	2	1	3	..	2	9	11	1	4	10	15
Abnormal Pulmonary Ventilation																
Atelectasis with hyaline membrane disease	..	..	..	..	..	..	..	..	4	5	..	9	4	5	..	9
Atelectasis without hyaline membrane disease	..	1	..	1	..	..	..	..	4	1	1	6	4	2	1	7

PERINATAL MORTALITY BY CAUSE OF DEATH, TIME OF DEATH AND BY BIRTH WEIGHT—1965—*Continued*

*Cause of Death**	*Before Labor*				*During Labor*				*Neonatal*				*Total*			
	500-999	*1000-2499*	*2500+*	*Total*	*500-999*	*1000-2499*	*2500+*	*Total*	*500-999*	*1000-2499*	*2500+*	*Total*	*500-999*	*1000-2499*	*2500+*	*Total*
Abnormal Pulmonary Ventilation (Con't)																
Hyaline membrane disease	..	..	..	..	..	..	..	..	..	4	1	5	..	4	1	5
Pulmonary edema and hemorrhages	..	..	..	..	..	..	..	..	..	1	..	1	..	1	..	1
Bilateral pneumothorax and mediastinal emphysema	..	..	..	..	..	..	..	..	..	..	1	1	..	..	1	1
Infection																
Pneumonia	..	..	1	1	..	..	..	..	..	2	1	3	..	2	2	4
Septicemia	..	..	..	..	..	..	..	..	..	1	..	1	..	1	..	1
Erythroblastosis	2	5	1	8	..	2	..	2	..	1	1	2	2	8	2	12
Other Conditions or Causes																
Intracranial hemorrhage	..	..	..	..	..	..	..	..	..	3	1	4	..	3	1	4
Multiple hemorrhages	..	1	..	1	..	..	..	..	..	1	..	1	..	2	..	2
Prematurity	..	..	..	..	..	..	..	..	1	..	..	1	1	..	..	1
Macerated, no cause determined	..	3	2	5	..	..	..	..	..	..	..	..	..	3	2	5
No cause determined	..	..	..	..	..	..	1	1	..	2	..	2	..	2	1	3
TOTAL	11	19	7	37	5	10	5	20	15	25	17	57	31	54	29	114

*Autopsies were performed in 104 of the 114 perinatal deaths.

LIVE BIRTHS, DEADBORN AND TOTAL BIRTHS, NEONATAL AND TOTAL DEATH RATES PER 100

1965

BY BIRTH WEIGHT IN GRAMS

(Including Twins and Triplets)

Weight in Grams	*Live Births*	*Neonatal Deaths*	*Neonatal Death Rate Per 100 Live Births*	*Deadborn*	*Total Births (Live and Deadborn)*	*Total Deaths (Neonatal and Deadborn)*	*Total Death Rate per 100 Total Births*
500– 999	17	15	88.2	16	33	31	93.9
1,000–1,499	28	9	32.1	14	42	23	54.8
1,500–1,999	62	7	11.3	7	69	14	20.3
2,000–2.499	195	9	4.6	8	203	17	8.4
2,500–2,999	971	9	0.9	6	977	15	1.5
3,000–3,499	1,868	3	0.2	5	1,873	8	0.4
3,500–3,999	1,095	3	0.3	1	1,096	4	0.4
4,000–4,499	263	2	0.8	..	263	2	0.8
4,500–4,999	42	..	..	..	42	..	..
5,000+	3	..	..	..	3	..	..
TOTAL	4,544	57	1.3	57	4,601	114	2.5
1,000 and over	4,527	42	0.9	41	4,568	83	1.8
1,500 and over	4,499	33	0.7	27	4,526	60	1.3
2,500 and over	4,242	17	0.4	12	4,254	29	0.7

MATERNAL MORTALITY FOR PERIOD

September 1, 1932—December 31, 1965

PAVILION, PRIVATE AND BERWIND OUTDOOR SERVICES

During this period there were 141 deaths in 161,737 discharged patients; a maternal mortality rate of 0.9 per 1,000 patients discharged, or 1.0 per 1,000 pregnancies. In 1965 there were 3 deaths. The causes of death for the total period are shown in the following table:

Cause of Death	*1932 to 1937*	*1938 to 1942*	*1943 to 1947*	*1948 to 1952*	*1953 to 1957* *†*	*1958 to 1962* ‡§	*1963*	*1964*	*1965*	*Total*	*Grand Total*	*Per Cent Total*
Infection												
Antepartum	1	..	..	..	..	..	..	..	..	1		
Postpartum												
Puerperal infection	4	..	1	..	..	..	..	..	..	5		
Peritonitis following C. S.	5	1	..	..	..	..	1	..	..	7		
Peritonitis following ruptured appendix	..	2	..	..	..	..	..	..	..	2		
Postabortal	1	3	..	1	1	..	..	..	..	6	24	17.0
Septic shock post abortal	..	..	..	..	..	1	..	..	..	1		
Endotoxic shock with secondary fibrinolysis, postabortal	..	..	..	..	..	..	..	..	#1	1		
Disseminated intravascular coagulation, postabortal	..	..	..	..	..	..	..	..	1	1		
Pneumonia												
Antepartum	2	..	..	..	..	..	..	..	..	2	8	5.7
Postpartum	4	..	1	..	1	..	..	..	..	6		
Hemorrhage												
Antepartum												
Placenta previa	1	..	..	..	..	..	..	..	..	1		
Premature separation of placenta	3	..	..	..	..	..	..	..	..	3		
Postpartum												
Vaginal delivery	4	2	3	..	..	..	..	..	..	9	19	13.5
Following cesarean section	2	1	..	..	..	..	..	..	..	3		
Ruptured uterus	1	1	..	..	..	..	..	..	..	2		
Ectopic pregnancy	..	1	..	..	..	..	..	..	..	1		
Toxemia												
Acute yellow atrophy	2	1	..	..	..	..	..	..	..	3	5	3.5
Eclampsia	1	..	..	1	..	..	..	..	..	2		
Cardiac disease												
Antepartum	2	3	3	5	3	..	..	..	..	16	24	17.0
Postpartum	3	1	..	1	1	1	1	..	..	8		
Bronchial asthma	..	..	..	..	..	1	..	..	..	1	1	0.8
Cushing's disease	..	..	..	..	..	1	..	..	..	1	1	0.8
Embolus	4	6	2	..	1	..	..	..	..	13	13	9.2
Massive necrosis of liver (5 weeks after transfusions)	..	..	..	..	..	1	..	..	..	1	1	0.8
Massive necrosis of liver ? viral hepatitis	..	..	..	..	..	..	**1	..	..	1	1	0.8
Pyelonephritis	2	..	..	1	1	..	..	..	..	4	4	2.8
Acute glomerulonephritis	..	..	..	..	..	..	..	x1	..	1	1	0.7
Subacute glomerulonephritis	..	..	..	..	..	1	..	..	..	1	1	0.7
Ischemic nephrosis	..	..	..	..	1	..	..	..	..	1	1	0.7
Necrosis of renal cortices	..	..	1	..	..	..	..	..	#1	2	2	1.4
Cerebrovascular accident	2	1	3	..	..	..	1	..	..	7	7	5.0
Anesthesia	1	1	..	..	..	1	..	..	..	3	3	2.1

*There were no maternal deaths in 1954 or 1960.
†Three of these deaths occurred after transfer to other services in the main hospital.
‡One of these deaths occurred after transfer to another service in the hospital.
§Two deaths occurred in patients admitted to other services in the hospital via Emergency Room.
**Died after transfer to another service in the hospital.
xDied after transfer to another service in the hospital, and 75 days after delivery.
#Transferred from outside hospital, postpartum.

MATERNAL MORTALITY FOR PERIOD

September 1, 1932—December 31, 1965

PAVILION, PRIVATE AND BERWIND OUTDOOR SERVICES—Continued

During this period there were 141 deaths in 161,737 discharged patients; a maternal mortality rate of 0.9 per 1,000 patients discharged, or 1.0 per 1,000 pregnancies. In 1965 there were 3 deaths. The causes of death for the total period are shown in the following table:

Cause of Death	*1932 to 1937*	*1938 to 1942*	*1943 to 1947*	*1948 to 1952*	*1953 to 1957* *†*	*1958 to 1962* ‡§	*1963*	*1964*	*1965*	*Total*	*Grand Total*	*Per Cent Total*
Transfusion reaction	..	..	2	..	..	..	..	..	..	2	2	1.4
Tuberculous meningitis	..	..	..	..	..	1	..	..	..	1	1	0.7
Tuberculosis, miliary	1	..	..	..	..	..	..	..	..	1	1	0.7
Choriocarcinoma	1	..	1	..	..	1	..	..	..	3	3	2.1
Carcinoma of breast	..	..	..	3	..	..	..	..	..	3	3	2.1
Carcinoma of liver	..	..	1	..	..	..	..	..	..	1	1	0.7
Carcinoma of thyroid	..	..	1	..	..	..	..	..	..	1	1	0.7
Melanocarcinoma skin of right buttock	..	..	..	1	..	..	..	..	..	1	1	0.7
Sarcoma (neurogenic 2, reticulum cell, 2)	..	..	1	..	3	..	..	..	..	4	4	2.8
Postoperative to granulosa cell tumors of ovaries (benign?)	..	..	..	..	1	..	..	..	..	1	1	0.7
Scleroderma	..	..	..	..	..	1	..	..	..	1	1	0.7
Blood dyscrasia-erythroblastic splenomegaly	1	..	..	..	..	..	..	..	..	1	1	0.7
Sickle Cell HcC disease (crisis)	..	..	..	..	..	1	..	..	..	1	1	0.7
Suicide (undelivered)	1	..	..	..	..	..	..	..	..	1	1	0.7
Colitis, subacute	..	1	..	..	..	..	..	..	..	1	1	0.7
Coma postpartum, cause not determined	..	..	..	..	..	..	..	1	..	1	1	0.7
Not determined (insufficient data)	1	..	..	..	..	..	..	..	..	1	1	0.7
TOTAL	50	25	20	13	13	11	4	2	3	141	141	100.0

*There were no maternal deaths in 1954 or 1960.
†Three of these deaths occurred after transfer to other services in the main hospital.
‡One of these deaths occurred after transfer to another service in the hospital.
§Two deaths occurred in patients admitted to other services in the hospital via Emergency Room.
**Died after transfer to another service in the hospital.
xDied after transfer to another service in the hospital, and 75 days after delivery.
#Transferred from outside hospital, postpartum.

STATISTICS

GYNECOLOGICAL DEPARTMENT

January 1, 1965—December 31, 1965

TOTAL DISCHARGES		2,750
Race		
Puerto Rican	74	
Non White	345	
Other	2,331	
TOTAL	2,750	

DIAGNOSIS ON DISCHARGE

Vulva	
Bartholin's gland abcess or cyst	83
Benign tumor	19
Carcinoma	8
Condylomata	9
Congenital abnormalities	1
Diseases of hymen	12
Leukoplakia	8
Vulvitis	13
Others of Vulva	38
Vagina and Perineum	
Benign tumor	18
Carcinoma	2
Congenital abnormalities	3
Cul-de-sac hernia	27
Cystocele	481
Rectocele	349
Gartner's duct tumor	3
Inclusion cyst	15
Old perineal laceration	3
Rectovaginal fistula	7
Relaxed outlet	313
Vesicovaginal fistula	6
Ureterovaginal fistula	1
Cervical vaginal fistula	1
Varix of vagina	1
Stricture	11
Vaginitis	69
Others of vagina and perineum	132
Cervix	
Carcinoma, adeno	10
Carcinoma, squamous (invasive)	99
Carcinoma, in situ (Stage 0)	34

Basal cell hyperactivity	67
Cervicitis	1,252
Endocervicitis	60
Congenital abnormalities	2
Descensus	149
Endometriosis	9
Erosion	223
Hyperkeratosis	18
Parakeratosis	2
Hypertrophy	71
Incompetent cervical os	13
Laceration	67
Leukoplakia	2
Myoma	11
Polyp	203
True ulcer	18
Other benign tumors	21
Squamous metaplasia	152
Stenosis	61
Cystic	921
Others of cervix	78
UTERUS	
Atrophic endometrium	266
Adenomyoma	13
Adenomyosis	113
Carcinoma	93
Carcinoma in situ	1
Endometritis	2
Endometriosis	30
Congenital abnormalities	19
Foreign body (1 incarcerated pessary, 39 IUCD)	40
Hematometra	1
Hypertrophy	28
Hyperplasia of endometrium	147
Menorrhagia	667
Metrorrhagia	640
Myoma	867
Polyp	226
Pyometra	2
Procidentia	68
Retroversion	324
Other malposition	44
Other benign tumors	1
Tuberculosis of endometrium (one patient)	2
Sarcoma	4
Others of uterus	132

DIAGNOSIS ON DISCHARGE—*Continued*

TUBE	
Benign tumor	11
Carcinoma	1
Congenital abnormalities	1
Endometriosis	12
Hematosalpinx	6
Hydrosalpinx	29
Pyosalpinx	10
Perisalpingitis	14
Salpingitis	195
Tubo-ovarian abscess	17
Others of tube	78
OVARY	
Carcinoma	64
Mesonephroma	1
Teratoma, malignant	1
Granulosa cell tumor, malignant	4
Congenital abnormalities	1
Corpus hemorrhagicum	18
Corpus luteum cyst	75
Dermoid cyst	38
Endometrial cyst	43
Endometriosis	31
Fibroma, fibroadenoma	19
Follicular cyst	48
Brenner tumor, benign	1
Granulosa cell tumor, benign	2
Perioophoritis	26
Parovarian cyst	15
Peripheral sclerosis	65
Prolapse	20
Pseudomucinous cyst, cystadenoma	22
Serous cystadenoma	56
Struma ovarii	2
Thecoma	3
Other cysts and tumors	58
Others of ovary	87
OTHER CONDITIONS	
Intraligamentary myoma	5
Endometriosis—other genital	16
Endometriosis—extra genital	3
Peritoneal inclusion cyst	5
Pelvic abscess, cellulitis	20
Pelvic peritonitis	8
History of pelvic tuberculosis	3
Stein-Leventhal syndrome	23
Syphilis or history of syphilis	32
Gonorrhea	3
Urethrocele	76
Other (miscellaneous), gynecological and associated pelvic conditions	812

CANCER ADMISSIONS

1965

	New Cases	*First Admissions of 1965*	*Total Admissions in 1965*
Cervix Uteri			
Invasive, Stages I-IV	36	66	110
Intraepithelial, Stage O	16	24	34
Corpus Uteri			
Carcinoma	29	52	92
Sarcoma	1	3	4
Carcinoma in situ	1	1	1
Ovary			
Carcinoma	35	46	64
Mesonephroma	1	1	1
Teratoma, malignant	0	1	1
Granulosa cell tumor, malignant	2	2	4
Vulva	6	7	8
Vagina			
Invasive	1	2	2
Tube	0	1	1
Bladder	1	2	3
Urethra	0	2	3
Total	129	210	328

OPERATIONS

Major	988
Minor	1,445
Total	2,433

TOTAL OPERATIONS AND PROCEDURES PERFORMED ON PATIENTS DISCHARGED FROM GYNECOLOGICAL SERVICE 1965

Vaginal and Perineal	
Dilatation of cervix	9
Dilatation and curettage	1,776
Cone biopsy of cervix	41
Other biopsy of cervix	908
Other biopsy	65
Insertion of pessary	24
Insertion of radium	62
Cauterization of cervix	47
Bartholin's excision	50
Bartholin's incision and drainage	26
Removal condylomata	9
Removal inclusion cyst	6
Removal Gartner's cyst	1
Hymenotomy, hymenectomy	20
Cervical repair	4
Polypectomy	108
Amputation cervix	18
Vulvectomy	3
Perineorrhaphy	1
Anterior colporrhaphy	228
Posterior colporrhaphy	203
Other vaginoplasty	13
Vaginectomy (2 total)	5
Vaginal myomectomy	19
Repair cul-de-sac hernia	13
Modified radical vaginal hysterectomy (modified Schauta procedure)	1
Vaginal hysterectomy	190
Shirodkar procedure	12
Tubal sterilization, transvaginal (3 with cryosurgery)	16
Colpotomy	36
Excision of cervical stump	11
Radical excision of vaginal vault	1
Vaginal removal of IUCD	21
Other vaginal operations	223
Abdominal Gynecological Operations	
Total hysterectomy	304
Subtotal hysterectomy	10
Myomectomy	60
Suspension associated with other surgery	25
Radical pelvic eviscerectomy	2
Radical hysterectomy and lymphadenectomy	71
Salpingectomy, unilateral	90
Salpingectomy, bilateral	179
Oophorectomy, unilateral	112
Oophorectomy, bilateral	177
Resection of ovary	141
Suspension of ovary	2
Removal of parovarian cyst	9
Tubal sterilization, (abdominal, 1 with cryosurgery)	5
Salpingostomy	26
Abdominal removal of IUCD.	6
Other abdominal operations	61
Urinary Tract Operations	
Cystectomy	3
Plication urethra	11
Suprapubic suspension urethra	13
Repair of vesicovaginal fistula	1
Transplantation, anastomosis ureters	4
Biopsy	12
Excision or cauterization urethral caruncle	2
Other operations	20
Rectal Operations	
Repair rectovaginal fistula	5
Hemorrhoidectomy	8
Polypectomy	3
Other operations	15
Other Abdominal Operations	
Exploratory laparotomy, no removal	30
Exploratory laparotomy, biopsy	148
Release of adhesions	116
Appendectomy	185
Repair hernia	17
Secondary closure	5
Colostomy	3
Other abdominal	40
Other Operations	
Excision breast tumors, benign	15
Paracentesis	18
Presacral neurectomy	3
Other operations	62
Non-Operative Procedures	
Examination under anesthesia	2,247
Proctoscopy	62
Cystoscopy	63
Therapy, Non-Operative	
Transfusions	177
X-ray	60

*This table refers to operations and procedures performed during the patient's hospital admission.

POST-OPERATIVE COMPLICATIONS

Among 2,433 operative 1,794 or 73.7 per cent had no post-operative complications. The following occurred among 639 patients who had post-operative complications:

	Number	*Per Cent of Total Operative Cases*
Febrile—etiology unknown	68	2.8
Febrile—pneumonia	7	0.3
Febrile—urinary tract infection	65	2.7
Febrile—thrombophlebitis	3	0.1
Febrile—infection operative site (9 abdominal, 5 vaginal)	14	0.6
Febrile—other cause	41	1.7
Shock—operative	2	0.1
Afebrile—urinary tract infection	51	2.1
Afebrile—thrombophlebitis	8	0.3
Afebrile—pneumonia	1	0.04

Some of the following complications occurring with a febrile course were included in the categories above also, and in some instances more than one complication occurred in the same individual:

	Number	*Per Cent of Total Operative Cases*
Cardiac arrest	2	0.1
Coronary occlusion	5	0.2
Other cardiac	7	0.3
Pulmonary embolus	1	0.04
Paralytic ileus	13	0.5
Intestinal obstruction	3	0.1
Atelectasis	9	0.4
Wound infection (in addition to 14 febrile wound infection above), abdominal	7	0.3
Wound disruption (16 abdominal of which 11 were superficial)	16	0.7
Septicemia	2	0.1
Pelvic abscess, cellulitis	12	0.5
Ureterovaginal fistula	1	0.04
Enterocutaneous fistula	1	0.04
Anemia	447	18.4
Hemorrhage	12	0.5
Hematoma	14	0.6
Psychosis or acute anxiety	6	0.2
Other nervous	2	0.1
Other digestive	7	0.3
Other respiratory	13	0.5
Other urinary	27	1.1
Other circulatory	6	0.2
Miscellaneous	33	1.4
TOTAL	906	

MORTALITY ON GYNECOLOGICAL SERVICE

FOR THE PERIOD—September 1, 1932—December 31, 1965

During this period there were 371 deaths in 61,274 discharged patients, giving a gross mortality of 0.6% or 6 per thousand patients discharged.

	*Postoperative Mortality**			
	1965		*1932–1965*	
	Operations	*Deaths*	*Operations*	*Deaths*
Major	988	4	22,411	133
Minor	1,445	1	32,421	62
TOTAL	2,433	5	54,832	195

The incidence of postoperative mortality = 0.2% (2.0 per thousand) for 1965 and for the whole period, 0.4% (3.6 per thousand).

The causes of death in 1965 are shown in the following table:

Cause of Death	*Number*
Acute septicemia and cervicitis	1
Carcinoma of cervix	10
Carcinoma of kidney	1
Carcinoma of ovary	7
Carcinoma of uterus	1
Malignancy, site of origin unknown	1
Cardiac failure	1
Total	22

*"Postoperative Mortality" as used in this table includes all deaths following any operative procedure, major or minor, provided the procedure was performed during the terminal hospital stay of the patient, irrespective of the duration between operation and death.

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